DSS-106
R. 4/90

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL SERVICES

CHILD'S MEDICAL RECORD

Name_____ DSS#_____

Birthdate_____ Medical Assistance #_____

MEDICAL HISTORY

Check if child has or has ever had the following illnesses (Record approximate date(s):

	Date of Illness		Date of Illness		Date of Illness
☐	Measles	☐	Heart Disease	☐	Joint/Muscle Pain
☐	German Measles	☐	Heart Murmur	☐	Convulsions/Seizures
☐	Whooping Cough	☐	Tuberculosis	☐	GI Problems
☐	Mumps	☐	Allergies	☐	EENT Problems
☐	Chickenpox	☐	Intestinal Parasites	☐	
☐	Scarlet Fever	☐	Anemia	☐	Urinary Problems
☐	Rheumatic Fever	☐	Jaundice		Other Problem

Does child use: Alcohol ___ Tobacco ___ Drugs ___ If yes, please explain_____

List any recent health problems (include inpatient and outpatient care). Describe illness, treatment, and treatment resources.

Is child taking any medication? (includes vitamins, iron, ASA, dilantin, cough and cold medicine) ____Yes ____ No
If yes, give condition requiring medication and name of medication: _____

Date last seen by physician _____ Date last seen by dentist _____

IMMUNIZATION	DATE	DATE	DATE	DATE
DPT				
Diph-Tet				
Polio				
Measles				
Rubella				
Mumps				

Immunization complete: Yes ___No____

Date of completion:_____

Name: _____ Birthdate: _____

DATES													
HEIGHT					HGB/HCT								
WEIGHT													
TEMPERATURE					RUBELLA TITER								
PULSE					RH FACTOR								
BLOOD PRESSURE													
URINE DIP STICK	PROTEIN												
	SUGAR												
	NITRATE												
	BLOOD												
BLOOD SUGAR	METHOD												
	RESULTS												
VISION	LEFT												
	RIGHT												
	BOTH												
HEARING		R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
	1000												
	2000												
	4000												

EYES	SPEECH	SKIN
EARS	HEART	POSTURE (spine)
NOSE	CHEST	NEURO/REFLEXES
MOUTH	ABDOMEN	BREAST
TEETH	EXTREMITIES	GENITALIA

FOR GIRLS ONLY:

Menarche: Age at onset _____ Frequency _____ Duration _____

Problems: (Explain) _____

Sexually active: Yes _____ No _____ Date of last menstrual period _____

Is patient using birth control? Yes _____ No _____

If yes,which method is now being used? Pill_____ IUD _____ Foam _____Condoms ____ Diaphragm____Other____

Has patient had any problems with pelvic/vaginal infections? Yes _____ No _____

COMMENTS: _____

_____

_____

_____ _____

Physician's Signature Date